## ATTACHMENT 8

Sample CMS 1500 claim form for outpatient mental health services in a county-owned clinic

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Recipient. Im A. MM   DD   Y	PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	$\neg$
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14. DATE OF CURRENT:    ILLAYES; First amplioning or mission of the precision of precision or mission or missi		• • • • •		
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locrify that the statements on the reverse apply to this bill and are made a part thereof.)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing  1 W. Williams  Anytown, WI 55555 87654321	□□ 1234			- 11
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  RENDERED (If other than home or office)  8. PHONE #  I.M. Billing  1.W. Williams  Anytown, WI 55555  87654321	31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AN	ID ADDRESS OF FACILITY WHERE SERVICES WERE		$-\parallel$
apply to this bill and are made a part thereof.)  T.M. Billing  1 W. Williams  Anytown, WI 55555 87654321		ED (If other than home or office)	& PHONE #	
工具 Courter MIM/DD/YY Anytown, WI 55555 87654321		l	•	
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SIGNED DATE PIN# GRP#	SIGNED DATE		PIN# GRP#	ΥΥ